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	175277	A. BUILDING _____ B. WING _____	R 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Revisit and Complaint investigation #KS 57846 and #KS58371. A revised copy of the 2567 was sent to the facility on 7-23-12.	{F 000}		
{F 279} SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 113 residents. The sample included 6 residents. Based on observation, interview and record review, the facility failed to provide a comprehensive care	{F 279}		6/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{F 279}	Continued From page 1	{F 279}		

plan or interventions for urinary incontinence for one of six sampled residents. (#1000)

Findings included:

- Resident #1000's annual Minimum Data Set (MDS) 3.0 dated 6/12/12 recorded the Brief Interview for Mental Status (BIMS) score was 5 which indicated severe cognitive impairment. The MDS recorded the resident required extensive staff assistance for transfers, dressing, toilet use and personal hygiene. The resident was frequently incontinent of urine and staff attempted a toileting program.

The July 2012 Medication Administration Record (MAR) recorded the physician's order for Lasix, give 120 milligrams (mg.) every 72 hours, dated 6/26/12. Lasix is a diuretic which increases urine output.

The incontinence Care Area Assessment (CAA) dated 6/16/12 recorded the resident was incontinent and unable to make his/her needs known because of his/her dementia diagnosis, and he/she received diuretics for edema. Staff should offer to take the resident to the toilet on schedule.

The facility lacked a toileting and incontinence care plan. The resident's care plans dated 6/19/12 for skin, activities of daily living, falls, hydration, pain and hospice did not address the resident's incontinence or toileting schedule.

The direct care staff Kardex (care guide), undated, directed staff to assist the resident to toilet upon rising, before or after meals, at

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{F 279}	Continued From page 2 bedtime and upon resident request. During an interview on 7/17/12 at approximately 5:00 P.M., direct care staff P stated staff assisted the resident to the toilet according to the Kardex which amounted to approximately every 2 hours. Observation on 7/17/12 at 9:13 A.M. revealed direct care staff R and direct care staff S assisted the resident to the toilet, and licensed staff I observed care and applied medication to the resident after care. Upon standing, the resident's shirt was wet in the front from the chest to the hemline and the pants were wet from the waistband to the shin area in the front, and from the waistband to the calf area in the back. Direct care staff R removed the resident's saturated brief and continued care. During an interview at that time, direct care staff R stated the resident poured a glass of water on him/herself at breakfast. Observation on 7/17/12 at approximately 4:25 P.M. revealed direct care staff P and direct care staff Q changed the resident and provided perineal care. The resident's brief was saturated with urine. During an interview at that time, direct care staff P stated staff checked the resident a little over 2 hours ago and he/she was dry. Direct care staff P stated the resident usually urinated heavily. During an interview on 7/17/12 at 9:26 A.M., licensed nurse I acknowledged the resident's clothing was wet and verified the resident urinated heavily because of his/her diuretic medication.	{F 279}		

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{F 279}	Continued From page 3 During an interview on 7/18/12 at 4:02 P.M., licensed nurse I stated previously, staff added a pad to the resident's brief because of heavy urination and intended to implement that intervention again; also at one time staff toileted the resident every 1 and ½ hours instead of every 2 hours. Nurse I acknowledged the facility did not have an incontinence care plan for the resident. During an interview on 7/18/12 at 4:03 P.M., administrative nursing staff D acknowledged staff did not develop an incontinence or toileting care plan for the resident. During an interview on 7/18/12 at 4:09 P.M., administrative nursing staff F stated he/she just developed the resident's care plan recently, and did not develop an incontinence/toileting plan and interventions. The facility provided the policy entitled Process for Plan of Care Development and Communication dated 7/1/10 directed, "The resident's plan of care is an interdisciplinary document to be used as a communication tool for all staff providing care. The resident Plan of Care shall identify the residents' needs, problems, strengths, risk factors and measurable goals ...The Plan of Care should be viewed as a work in progress and changes made as the resident's needs change. It is a process that evolves to meet the needs of the resident over the course of their stay...The plan of care will include: a. A problem statement; developed as a result of comprehensive review b. Measurable resident centered goals c. Time frames for meeting those goals d. Interventions designed to assist the resident in	{F 279}		

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{F 279}	Continued From page 4 meeting the goals." The facility failed to develop a comprehensive care plan and interventions for this resident's incontinence and toileting needs.	{F 279}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility identified a census of 113 residents. The sample included 3 residents investigated for skin problems. Based on observation, interview and record review, the facility failed to identify a bruise for resident #1000, and failed to identify an abrasion for resident #1005. Findings included: - Resident #1000's annual Minimum Data Set (MDS) 3.0 dated 6/12/12 recorded the Brief Interview for Mental Status (BIMS) score was 5 which indicated severe cognitive impairment. The MDS recorded the resident required limited staff assistance for bed mobility and locomotion on and off the unit, extensive staff assistance for transfers, dressing, toilet use and personal hygiene, and staff supervision for eating. The resident did not walk, was at risk for developing	{F 309}		6/30/12

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{F 309}	Continued From page 5	{F 309}		

pressure ulcers and did not currently have any pressure ulcers.

The pressure ulcer Care Area Assessment dated 6/16/12 recorded the resident was incontinent, received diuretics (medication that increased urine output), was not able to make his/her needs known, used a wheelchair for mobility, needed assistance with bed mobility, and had poor nutritional intake.

The skin care plan dated 6/19/12 directed staff to monitor his/her skin during his/her bath and report any changes to the change nurse, administer the resident's itching medication, administer aspirin which may increase bruising, watch the resident when he/she was out on the unit and guide him/her away from anything that he/she might bump into, keep his/her fingernails trimmed and filed weekly, use an antibacterial scrub during bathing, weekly skin assessments and quarterly Braden Scale Assessments (assessment to identify pressure ulcer risk), consult with the doctor if the resident had new open skin areas for treatment orders, and wash the resident's hands before meals and after he/she used the toilet.

The direct care staff's Kardex (care guide) directed staff to check the resident's skin for rashes and open areas during daily care and report them to the nurse.

Observation on 7/17/12 at approximately 4:25 P.M. revealed direct care staff Q and direct care staff P provided incontinent care to the resident in his/her bed, rolled the resident to his/her left during care, and observation revealed a bruise on

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{F 309}	Continued From page 6 the back of the resident's right arm, above the elbow. Review of the Treatment Administration Record (TAR) dated 7/12 lacked evidence staff monitored the bruise on the back of the resident's arm. Review of the Bath Sheet dated 7/17/12 recorded the resident had bruises on the front of his/her arms, and staff circled the entire arm from elbows to the hands on the human figure form, but did not identify any specific bruises. Review of the Weekly Skin Check dated 7/16/12 and 7/18/12 recorded staff monitored the resident's bruises to his/her bilateral upper extremities, but did not identify the bruises on the human figure form. During an interview on 7/18/12 at 3:34 P.M., licensed nurse I stated direct care staff did not report the resident's bruise to him/her. Nurse I stated staff should report any new skin problem and the nurse would then complete the "bruise packet" which included assessment, monitoring, interventions and incident report, give it to administrative nursing staff, and note the skin area on the TAR for monitoring. Nurse I stated he/she completed a skin assessment earlier in the day for the resident and did not see the bruise, so he/she did not document it on the Weekly Skin Assessment Sheet or add it to the TAR. During an interview on 7/18/12 at 3:36 P.M., direct care staff P stated he/she gave the resident a shower the day before but did not notice the bruise on the resident's arm. Staff P stated when	{F 309}		

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staff identified a new skin problem, they should document it on the shower sheet and notify the licensed nurse.

During an interview on 7/18/12 at 3:54 P.M., administrative nursing staff D stated he/she observed the resident's bruised arm and acknowledged staff did not identify the bruise, and acknowledged direct care staff did not identify specific bruises on the bath sheet so he/she could not verify if the bruise was new. Nursing staff D stated he/she expected licensed nurses to fill out the packet for bruises and turn it in, and he/she expected direct care staff to report new skin conditions to the licensed nurse.

The facility provided the policy entitled Skin and Wound Management Program Overview dated 6/1/07 which directed staff, "Qualified staff will assess all residents weekly, from "head to toe" to identify any new pressure ulcers or other types of skin breakdown. Results of these assessments will be documented in the resident's medical record by a licensed nurse."

The facility failed to identify and monitor the resident's skin problem.

- Resident #1005's annual Minimum Data Set 3.0 Assessment (MDS) dated 6-27-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 7, which indicated the resident had moderately impaired decision making skills. The resident required extensive assist with bed mobility, transfers, locomotion, dressing, toilet use and personal hygiene, and required supervision with eating. The MDS documented the resident as incontinent of bowel and bladder,

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at risk for pressure ulcers, and had 1 un-stageable pressure ulcer with necrotic tissue (eschar).

The updated 7-11-12 care plan documented the resident at risk for skin problems and interventions included monitoring the skin during baths, and perform weekly skin assessments.

Record review of the wound assessments documented on 7-10-12 revealed the resident with an abrasion to the left ankle. The record lacked documentation of a facility investigation of the wound notification to the physician, family and/or Durable Power of Attorney (DPOA), and lacked an assessment of the wound that included measurements and/or treatment orders.

Observation on 7-17-12 at 2:50 P.M. revealed the resident lay in bed and complained of pain throughout his/her body. The resident had a special pressure relieving boot on his/her left foot. Staff removed the resident's boot and sock and revealed an un-stageable pressure ulcer on the resident's left heel. The pressure ulcer had a dark black, brown scab over it and the surrounding skin was dry and flaking. Observation of the medial malleolus bone of the left outer ankle revealed a thick dark brown, black scabbed area approximately 0.5 - 1.0 centimeters (cm) circumference. The surrounding tissue was red. The resident also had a wound on the outer aspect of the left foot distal to the little toe with a dark brown, black scab and measured approximately 0.1 cm circumference.

Record review of the weekly skin monitoring sheet dated 7-12-12 documented the resident

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with a left heel pressure ulcer and lacked documentation of any other wounds on the left foot.

Record review of the bathing sheets documented the resident received a bath on 7-12-12 and documented the pressure ulcer only on the resident's left heel. The certified nursing assistant and the licensed nurse signed the form.

During staff interview on 7-17-12 at 3:20 P.M. licensed staff H was unaware of the wound on the resident's left ankle and the wound on the outer aspect of the left foot distal to the little toe. Licensed staff H stated he/she would notify the physician today.

During staff interview on 7-18-12 at 9:00 A.M. administrative nurse D stated he/she monitored the wounds weekly and the nurses provided the daily treatments to the wounds.

During staff interview on 7-18-12 at 1:56 P.M. administrative nurse E acknowledged the record lacked an investigation of the abrasion on the resident's left ankle wound and staff should have completed an investigation.

The 6-1-07 facility provided Skin and Wound Management Program Overview Policy and Procedure documented that qualified staff assessed all residents weekly, from "head to toe" to identify any new pressure ulcers or other types of skin breakdown. Results of the assessments were documented in the resident's medical record by a licensed nurse. When a break in the skin integrity was identified, the licensed nurse documented a detailed assessment in the

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medical record including type, size, stage, location, drainage, and odor of the area, obtain a treatment order, document a detailed personalized care plan and notify the Interdisciplinary Skin/Wound Management Committee. The licensed nurse communicated all identified breaks in skin integrity and associated information to the attending physician and family and documents the notifications in the medical record.

During record review the nurse's note on 7-12-12 documented staff received an order for a Z-pak (an antibiotic medication) and Robitussin (a cough medication) for an upper respiratory infection (URI). Record review of the telephone order directed staff to give the medication for 5 days. The medical record lacked any further documentation regarding assessment of the resident's condition while on the medication.

During observation of cares on 7-17-12 at 2:50 P.M. direct care staff O informed licensed nurse H the resident did not feel well and the resident had audible wet respiratory sounds.

During staff interview on 7-18-12 at 7:59 A.M. licensed nurse J stated the nurses charted on residents with antibiotics every shift and documented their findings in the nurse's notes. He/she also stated sometimes they documented in the Treatment Assessment Record (TAR). After reviewing the resident's chart and the TAR, he/she acknowledged the record lacked documentation that staff monitored the resident's URI.

During staff interview on 7-18-12 at 7:30 A.M.

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{F 309}	Continued From page 11 administrative nurse D stated the resident was admitted to the hospital last evening for an elevated temperature and respiratory problems. The facility failed to investigate the cause of the ankle wound, failed to document a detailed assessment of the wound, failed to notify the physician, and family/DPOA, and failed to assess the resident's respiratory illness with use of antibiotic therapy.	{F 309}		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 113 residents. The sample included 3 residents investigated for accidents. Based on observation, interview and record review, the facility failed to provide interventions to prevent falls for resident #1000. Findings included: - Resident #1000's annual Minimum Data Set (MDS) 3.0 dated 6/12/12 recorded the Brief Interview for Mental Status (BIMS) score was 5 which indicated severe cognitive impairment. The MDS recorded the resident required limited staff assistance for bed mobility and locomotion on	F 323		

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and off the unit, extensive staff assistance for transfers, dressing, toilet use and personal hygiene, and staff supervision for eating. The resident did not walk, and had 1 fall without injury since the prior assessment.

The falls Care Area Assessment (CAA) dated 6/16/12 recorded the resident did not remember that he/she was unable to transfer or stand without assistance. He/she fell in April attempting to transfer from the toilet to his/her wheelchair without assistance.

The falls care plan dated 6/19/12 directed staff to provide a wide toilet riser over the toilet to help stabilize the resident during toileting, on 1/10/12 staff placed the resident on the Falling Star Program, on 1/5/12 staff placed an infrared alarm on the wall next to the resident's bed, on 1/5/12 placed anti-roll backs on the resident's wheelchair to keep it from rolling out, if the resident tried to stand up unassisted, on 8/9/11 be aware that after meals the resident wanted to go back to his/her room to use the toilet or put him/herself to bed, 2 staff assistance using a gait belt to transfer safely, on 7/25/11 staff provided a low air loss mattress, on 9/29/10 staff placed the bed in the low position when in bed with the fall mat beside the bed, on 7/27/10 staff placed an alarm on the bed to alert staff if the resident tried to self-transfer, checked the alarm function every shift, on 3/23/10 staff anticipated the resident's needs like bathroom issues, eating and grooming, reminded the resident to call for assistance when he/she needed "repairs" on something in the room, and 7/7/12 provided non-slip socks or shoes to prevent feet from slipping possibly causing a fall.

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The Fall Risk Assessment dated 10/15/11 recorded the score was 31 which indicated the resident was at a high risk for falls.

Review of the fall investigation dated 6/16/12 revealed staff found the resident on the bathroom floor. He/she tried to transfer him/herself off the toilet. The Post Fall Investigation dated 6/16/12 recorded, "Resident needs adequate toileting program." The immediate intervention was "toileting program as appropriate."

The facility lacked a toileting care plan for the resident.

Review of the fall investigation dated 7/11/12 revealed staff found the resident on the fall mat on the floor next to his/her bed. The immediate intervention was "toileted, replace bed strip alarm, toilet every 2 hours while awake".

Observation on 7/17/12 at 9:13 A.M. revealed direct care staff R and direct care staff S assisted the resident with transfer from his/her wheelchair to the toilet. Both staff assisted the resident and used a gait belt for the transfer.

During an interview on 7/17/12 at approximately 5:00 P.M., direct care staff P stated the resident was at risk for falls and staff should not leave the resident alone on the toilet.

During an interview on 7/18/12 at 3:11 P.M., administrative nursing staff D acknowledged staff did not put any new effective interventions in place for the 6/16/12 and 7/18/12 falls and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175277	A. BUILDING _____ B. WING _____	R 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON WOODS AT ALVAMAR	1501 INVERNESS DR LAWRENCE, KS 66047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 clinical record lacked documentation that staff discussed appropriate interventions to prevent falls for the resident. The facility provided the policy entitled Incident/Accident Investigation Process dated 6/1/12 which directed, "A corrective plan of action will be developed and implemented based on identified problem areas." The facility failed to implement interventions to prevent falls for this dependent resident.	F 323		